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INTERNATIONAL CLINICS

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Clinical Case Studies

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FROM THE RECORDS OF THE
PITTSBURGH DIAGNOSTIC CLINIC
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FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Female Married Age 36 years

CHIEF COMPLAINTS

Pain in the right upper abdomen.
Backache.
Fatigue.

PRESENT ILLNESS

During the past eight or ten years the patient has been subject to recurring attacks of "indigestion"; these usually occur in an acute form once or twice a year, manifesting themselves with severe pain in the right upper abdomen, the attacks lasting ten or fifteen minutes. During the attack the pain is quite intense, radiating to the back and to the tip of the right scapula, and there is a sense of fullness in the epigastric region. Between attacks she has felt very well although she has always been more or less conscious of her stomach after taking food. Food seems to cause the accumulation of gas in the stomach and bowels, relieved only by some of the alkali preparations. This state of affairs continued until about five weeks ago when she had an unusually severe attack of upper abdominal pain. The pain was similar in character to her previous attacks, but this time it was very resistant to medication. Morphine and sedatives gave little relief. She vomited and the stools were clay colored for several days. The pain persisted over a period of thirty-six hours, and she was confined to bed for three days. It gradually subsided, but one week ago she had another attack, this time not as severe, but some blood was noticed in her stools.

Her appetite has been good, bowels have been regular; the abdominal pain is associated with severe headaches. Her vision is good when corrected with glasses. She is not particularly sub-

ject to colds, but states that she has an infected right antrum which causes some trouble. She has noticed some dyspnea on exertion and particularly when climbing stairs. This is aggravated by gas in her stomach. She also complains of considerable backache in the lower lumbar region; there are no urinary symptoms. She tires very easily and is unable to carry on with her usual duties without becoming exhausted. She sleeps rather poorly and awakens frequently during the night. During the past ten years she has gained some in weight. Two months ago she weighed 186 pounds; her average weight, however, has been around 175. At the present time she weighs 168 pounds.

PAST HISTORY

Patient as a child was never strong and robust. During childhood she had spinal meningitis. At the age of 16 years she had an ovarian cyst removed and uterine ligaments shortened; ten years ago following an abortion she had a pelvic infection which confined her to bed for twelve weeks.

Personal history—patient is 36 years of age, married, two children ages 11 and 5 years. She is a house wife, habits are regular. Menstrual periods are regular, although accompanied by considerable pain.

PHYSICAL EXAMINATION

GENERAL

Height 65 inches Weight 168 pounds Temperature 98°

Patient is a normally developed, somewhat obese, adult female; she has a slight degree of pallor and appears fatigued. There is no evidence of cyanosis or jaundice. Her mental attitude, gait and speech are normal.

HEAD AND NECK

Eyes—pupils are equal, react to light and accommodate to distance; ears and nose—negative. Mouth—throat is negative, tongue is clean, numerous teeth are missing, those remaining appear well preserved. Neck is negative.

THORAX

Chest is normal shape, well nourished, respirations are regular and even. Lungs are clear throughout.

Heart—the apex beat can be palpated in the fifth intercostal space, midclavicular line. Action is fairly strong and regular, rate is 78 per minute. There are no murmurs or thrills.

ABDOMEN

Abdomen is normal shape, with a tendency to obesity. There is very definite tenderness over the upper abdomen; the tenderness is noticeable on deep pressure to the left of the umbilicus, extending upward to the midepigastric region and over the right abdomen beneath the costal border. There is some muscle resistance on pressure and deep pressure causes considerable pain. No mass can be felt. Liver is not enlarged, spleen and kidneys cannot be palpated.

EXTREMITIES

There is no edema; reflexes are within normal limits. Pulse—fairly strong and regular, rate is 78 per minute. Skin is negative.

BLOOD PRESSURE

Systolic, 116.
Diastolic, 70.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.

GENERAL HISTORY

White Female Single Age 23 years

CHIEF COMPLAINT

Fainting spells.

PRESENT ILLNESS

Onset four years ago (1924) when she had her first fainting spell, this occurring one year after an appendectomy. The circumstances and description of the first attack are as follows. While the patient was sitting in a chair playing solitaire, the father and mother noticed that she was drooped forward, apparently unconscious. When they attempted to arouse her, she slumped forward and was caught by the father and mother, who carried her to bed. She was apparently absolutely limp and unconscious, so they thought she had fainted. She was put to bed and in a few minutes she could be roused sufficiently so she would mutter answers, but she seemed quite confused, semi-stuporous and would relapse into apparent sleep when not disturbed. For the next three days she remained in this condition, although she would answer questions when spoken to and would eat, or get up and go to the bath room when so instructed. During these three days she complained a great deal of severe headaches and a bad taste in the mouth. There was no twitching, no vomiting, and no loss of sphincter control. In about three days she had completely recovered, coming out of her semi-stuporous condition gradually. The patient thus remained perfectly well until one year later when in the early morning her mother heard her muttering and moaning while she was in bed, and on going to her found that she had bitten her tongue. This second attack was followed by the same semi-stuporous, somewhat confused state of mind, but it lasted only twelve hours. This second attack

was in September, 1925, and during the succeeding autumn she had one or two additional attacks, very much like this second one. In 1926 she had three or four, separated by two or three months, but during the past eighteen months there have been only two or three attacks. Practically all of these occurred when she was in bed; in most instances the only evidence they have of the attacks is when they find her in a semi-stuporous condition, complaining of severe headache. They have noticed, however, that for one or two days preceding the attack she will develop a very bad color, "sort of sallow and dull," as they describe it, and she is also apt to complain of vague intestinal symptoms such as belching of gas and constipation. Some of the attacks that have been seen are apparently accompanied by twitching and slight convulsive seizures. In at least one instance there was involuntary passage of urine. The patient herself has very little recollection of the fainting spells. She does state, however, that preceding a daytime attack she will suddenly note a peculiar feeling of mental detachment as though her thoughts were slipping away from her, and in a number of instances she has been able to hold onto these thoughts by effort and thus ward off an attack. Of course, she is not conscious of any such preliminary sensation when the attacks occur at night, as most of them do. There is no evident relation to menstruation, the menstrual history being quite normal.

PAST HISTORY

In general, she has always been perfectly well and normal in every respect with the exception of a tendency to gastro-intestinal disturbances characterized by bilious attacks. When born she was jaundiced and this continued for about three months after birth. She had a severe attack of jaundice at the age of 14. Since young girlhood she was subject to frequent bilious attacks characterized by a vague feeling of indigestion and tendency to nausea and vomiting. The appendix was removed five years ago because of a mild attack of appendicitis characterized mostly by vomiting, not a great deal of pain. No headaches or trouble with the

eyes or ears. About three years ago she complained of a slight abnormal feeling behind the lower sternum and an x-ray examination by a physician was made who reported an enlarged thymus and treated this with three applications of x-ray, reporting then that the gland had returned to normal size. No history of any genito-urinary disturbances. Menstruation always normal.

Habits—regular and normal for an active, healthy, young girl.

Family history—entirely negative.

PHYSICAL EXAMINATION

GENERAL

Height 66½ inches Weight 105½ pounds Temperature 98.6°

Patient presents normal build, muscular development and nourishment. No signs of undue introspection or nervous tendency; no emotional instability.

HEAD AND NECK

Ears—negative. Eyes—slightly prominent; pupils are equal, round, react normally and associated movements normal. Mouth—teeth well preserved, gums are clean. Throat—tonsils removed, small amount of lymphoid tissue remaining; no evidence of infection. Glands—no general enlargement. Thyroid—slight diffuse enlargement; no nodules.

THORAX

Lungs are clear throughout.

Heart—normal size, rate is 72, regular in force and rhythm. Sounds are clear, no murmurs. Pulse—72, regular. No abnormal thickening of vessel wall.

ABDOMEN

Normal contour. Respiratory movements free. In the right upper quadrant one feels a small, round mass extending from under the costal margin during deep inspiration, suggesting a small, firm gall bladder. This is not tender. Liver to costal margin, edge not felt. Spleen not felt. No abnormal peristalsis.

EXTREMITIES

No edema; reflexes are all normal; no tremor.

BLOOD PRESSURE

Systolic, 95.

Diastolic, 70.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.